DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

Canc frp: Apr 95
IN REPLY REFER TO
BUMEDNOTE 6150
BUMED-335
19 Apr 94

BUMED NOTICE 6150

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: NAVMED 6150/20 (REV. 1-94), SUMMARY OF CARE

Ref: (a) MANMED Chapter 16
(b) NAVMEDCOMINST 6150.1
(c) Joint Commission on the Accreditation of Healthcare Organization, "Accreditation Manual for Healthcare Organizations"

Encl: (1) NAVMED 6150/20 (Rev. 1-94), Summary of Care

1. Purpose. To establish guidelines and procedures for the use of enclosure (1) per references (a) through (c).

2. Scope. Applies to all health records (HRECs) and outpatient medical records (ORECs) of all eligible beneficiaries being treated at naval medical treatment facilities.

a. Introduces a change to NAVMED 6150/20. The new form shall be phased into existing records by replacing older forms which are either filled or worn.

b. Problems summary lists (PSLs) already present in the records shall be retained in the record. It is not necessary to completely copy entries from the old form onto the new form. Only current medical problems, chronic or long-term medications, and other significant health items need to be entered on the new form, in addition to the appropriate items listed in the "Health Maintenance Section" of the new form.

c. All new records shall incorporate enclosure (1).

3. Background. Summary of care (SC) forms assist with providing quality medical care and continuity of care for all outpatient beneficiaries. SCs enable effective continuity of medical care for outpatients and comply with requirements of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which state that active duty, family members, retirees, and other beneficiaries' medical records shall contain a summary list of relevant conditions and medications that significantly affect the patient's health status. The purpose of this list is to provide physicians and other providers with a concise overview of the patient's medical status, including information relative to health surveillance and health maintenance. Further, the SC shall facilitate coordinated management of the patient's health

care, especially on the occasion of permanent or temporary transfer of military personnel and their dependents.

4. Responsibility

a. The ultimate responsibility for initiating and updating the SC rests with the physician in charge of the patient at the time a particular condition or problem is identified, or when health maintenance is performed.

b. Nonphysician health care providers are authorized to enter information on the SC under the following guidelines:

(1) Privileged nonphysician providers may make SC entries of historical clinical data which is already documented in the chart without mandatory consultation with a physician. Consultation with a physician is required in conjunction with the SC of newly diagnosed or newly documented problems.

(2) On shipboard and at isolated duty stations where a physician is not available, nonphysician health care providers may record significant problems. In all such instances, a review of the SC shall be incorporated in the HREC review during routine visits by physician supervisors.

(3) Nurses, physician assistants, and hospital corpsmen are authorized to enter data concerning documented allergies, and all information listed in the health maintenance section. This information shall be reviewed by the privileged provider overseeing the patient's care.

5. The Medical Record

a. All medical records shall contain a summary list of relevant conditions and medications that significantly affect the patient's health status. This list provides a concise overview of the patient's medical status, including information relative to health surveillance and health maintenance.

b. The SC shall remain a permanent part of HRECs and ORECs. It shall always be the topmost form on the left side of all medical records (except inpatient records).

c. The SC shall be used to conspicuously document in each patient's HREC or OREC a summary list of past significant surgical procedures and past and current diagnoses or problems to facilitate ongoing provision of effective medical care.

d. Record legibly and file the SC on the top left side of the medical record jacket. Do not repeat problems or diagnoses that recur during ongoing treatment on the SC.

e. Document on the SC the past significant surgical procedures and past and current diagnoses or problems. Do not repeat, on the SC, problems or diagnoses that recur during ongoing treatment.

6. Initiating and Updating the SC. The SC is initiated for each patient at the time of the initial visit for care. If the patient has no condition warranting entry on the SC, the statement "Negative Review" shall be entered and the health care provider shall sign and date the entry. The SC includes, but is not limited to:

a. Significant surgical and invasive conditions.

b. Significant medical diagnosis and conditions.

c. Known adverse and allergic reactions to drugs.

d. Current or recent (long-term) medications.

e. Health maintenance information.

f. Health surveillance information.

g. The initial SC includes items based on any initial medical history and physical examination.

h. The SC is updated to facilitate locating relevant information in the medical record.

i. When significant information concerning the patient is located in another record, a written notation at the relevant item in the SC indicates where the other information is located.

7. Completion of the SC

a. Patient identification data must be completed on each form.

b. The SC shall include, at a minimum, the following:

(1) Significant medical conditions. At a minimum, this includes chronic disease (such as hypertension, diabetes, arthritis, alcohol abuse, etc.) and acute recurrent illnesses (such as recurrent urinary tract infection, recurrent otitis media, recurrent vaginitis, recurrent bronchitis, etc.).

(2) Significant surgical conditions. This includes all procedures requiring general or regional anesthesia and any procedures likely to have a long-term effect on the patient's health status.

(3) Hemoglobin (G6PD) and sickle cell trait shall be completed as initial entries under health surveillance.

(4) Occupational health surveillance activities such as "Asbestos Program," "Hearing Conservation Program," "lead exposure," etc., shall be listed in the health maintenance section.

(5) Known adverse and allergic reactions to drugs. Any allergies or untoward reactions to drugs shall be noted in the medical alert section.

(6) Record all current or recently used medications which are prescribed for chronic conditions, or for 90 days or more.

(7) The date of the health maintenance functions shall be entered in pencil. This shall facilitate erasure and expected updating.

c. Only approved naval medical abbreviations shall be used on the SC.

d. SC entries must be legible.

e. Significant medical and surgical conditions must be listed clearly and concisely. The SC is not meant to be a sick call log. Questionable or problem diagnosis; "rule outs," i.e., rule out pneumonia, gastroenteritis, viral syndrome, etc.; and routine complaints, such as upper respiratory infections, single episode of urinary tract infections, etc. Short-term medications shall <u>not</u> be on the SC.

f. Occupational health program documentation, including the date the service member or employee is enrolled and terminated from specific programs, must be documented on the SC. Documentation may be completed by the occupational health nurse, or other occupational health care provider in the occupational health department.

g. As new conditions are identified, the health care provider shall add them to the list and enter the date in the appropriate column.

h. As conditions resolve or become inactive, this status shall be noted above the statement of the problem, and the date added to the date column.

i. The SC shall be reviewed and revised as necessary at the time of each patient visit.

j. If the SC becomes damaged and must be replaced, information from the original SC may be transcribed to the new

form by hospital corpsmen or medical records personnel, but the transcription shall be verified against the original by responsible individuals as designated by the commanding officer. Where there is any question concerning accuracy or interpretation of information, clarification by a physician or other privileged provider shall be obtained. The original SC form may be discarded only when all information on the form has been transcribed and verified on the new form.

8. Yearly Review. Review contents during yearly medical record verifications and before transfer of HRECs and ORECs.

9. Action. All addressees shall ensure compliance with the requirements set forth in this notice.

10. Form. NAVMED 6150/20 (Rev. 1-94), Summary of Care, S/N 0105-LF-017-9000, may be requisitioned through the Navy Supply System per NAVSUP P-2002D. The estimated date of supply is August 1994.

11. Cancellation Contingency. Canceled upon incorporation into reference (a).

D. F. HAGEN

Fold along line. File on left side of folder.

File as top page on left side of folder.

Summary of Care

(This form is subject to the Privacy Act of 1974)

No.	Significant Health Problem	Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
	Exceptional Family Member Prog.	

Medical Alert *(SBE Prophylaxis, allergies, other)*
Alcohol:
Tobacco:

Medications	Start	Stop

	Hospitalization/Surgery	Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.	**Advance Directive Provided:**	
11.	**Advance Directive Returned:**	
12.		

Health Maintenance	Date of Last Test *(Pencil entry)*
Prostate Exam	
RPR	
G6PD / GPAB	/
Stool GUAIAC	
Mammogram	
Chest X-Ray	
ECG	
Birth Control Method	
PAP Smear	
Sickle Cell Trait	
HIV Screen	
Other	

(Continue significant health problems, medications, hospitalizations/surgery on reverse)

Space for Mechanical Imprint	Name of Patient (Last, First, Middle Initial)	Sex
	Year of Birth / Name of Sponsor	
	SSN. or I.D. No. / Relationship to Sponsor	
	Case File Maintained at:	

No.	Significant Health Problems	Date	Medications	Start	Stop
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					
31.					
32.					

	Hospitalization/Surgery	Date
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
26.		

Health Maintenance	Date of Last Test *(Pencil entry)*